FACEY MEDICAL GROUP

PERSONAL MEDICAL HISTORY

(Please complete both pages as accurately as possible)

NAME: _____ CHART NUMBER: _____

Today's Date: _____ Age: _____ Sex: _____ Height: _____ Date of Birth: _____

Marital Status: ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed Occupation: _____

PLEASE LIST YOUR IMMEDIATE COMPLAINTS:

ALLERGIES: ◯ NONE ◯ YES, LIST INCLUDING MEDICATIONS, FOODS, POLLENS		

CURRENT MEDICATIONS & DOSE ◯ NONE		
1-	5-	9-
2-	6-	10-
3-	7-	11-
4-	8-	12-

PAST ILLNESSES -	Yes	No	Unc		Yes	No	Unc		Yes	No	Unc
Measles				Mumps				Migraine Headaches			
Rubella				Rheumatic Fever				Chicken Pox			
Mononucleosis				Meningitis				Hernia			
Pneumonia				Diabetes				Syphilis			
Emphysema				Thyroid Disease				Other Venereal Diseases			
Asthma				Arthritis				Broken Bones			
Bronchitis				Gout				Nervous Breakdown			
Kidney Stone				Cancer (type:)				Suicide Attempt			
Kidney Infection				Colitis				Depression (requiring meds)			
Ulcers				Diverticulitis				Drug/Alcohol Abuse			
Hepatitis				Irritable/Spastic Bowel				Major Head Injury			
Liver Disease				Heart Attack				Transfusions			
Gallbladder Disease				Heart Murmur				Other Major Illnesses/Injuries.			
AIDS				Stroke							
Bleeding Tendencies				High Blood Pressure							
Tuberculosis				Heart Problem							
Positive TB Test				Epilepsy / Seizures							

MALES ONLY	Yes	No	Unc		Yes	No	Unc		Yes	No	Unc
Enlarged Prostate				Prostate Infection				Epididymitis			
Testicle Problem				Urine Infections				Other -			

FEMALES ONLY	Yes	No	Unc		Yes	No	Unc		Yes	No	Unc
Abnormal Pap Smear				Benign Breast Lump				Ovarian Cysts			
Uterine Fibroids				Pelvic Infection				Urine Infections			
PMS				Painful Periods				Contraception (type) -			
Age at First Period -				Periods Regular?				Date of Last Period -			
Number of Pregnancies -				Number of Deliveries -				Miscarriages/Abortion # -			

PAST SURGERIES (type / year) ◯ NONE		SERIOUS ACCIDENTS: ◯ NONE
1-	4-	1-
2-	5-	2-
3-	6-	3-

PAST EXAMS (Date:)	Yes	No	Unc	TEST NAME (Date:)	Yes	No	Unc		Yes	No	Unc
Physical				Stool Hematest				Mammogram			
Pap Smear				Sigmoidoscopy				TB Test			
Other Tests -											

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PERSONAL MEDICAL HISTORY (continued)

NAME: CHART NUMBER:

IMMUNIZATIONS:	Yes	No	Date		Yes	No	Date		Yes	No	Date
Tetanus				Flu/Influenza				Pneumonia			
Measles				Rubella				Polio			
Tuberculosis (BCG)				Hepatitis				Other:			

FAMILY HISTORY:	If Living, Age & Health	If Deceased, Age at Death & Cause
Father's Father:		
Father's Mother:		
Mother's Father:		
Mother's Mother:		
Father:		
Mother:		
Brother(s):		
Sister(s):		
Son(s):		
Daughter(s):		
Spouse:		

HAS ANY BLOOD RELATIVE HAD:	Yes	No	Who
Heart Attack			
Heart Disease			
High Blood Pressure			
Stroke			
Breast Cancer			
Cancer			
Type -			
Insulin Diabetes			
Non-Insulin Diabetes			
Sickle Cell Disease			
Asthma			
Tuberculosis			
Thyroid Disease			
Emotional Disorders			
Alcohol/Drug Abuse			
Migraine Headaches			
Bleeding Tendencies			
Other:			

HABITS: SMOKING	Yes	No
Do you smoke now?		
Did you ever smoke?		
How much do/did you smoke? (packs per day)		
For how long? (years) If you quit, what year?		
What do/did you smoke? ○ cigarettes ○ cigars ○ pipe		

DRINKING	Yes	No
Do you drink alcohol?		
Have you ever had a drinking problem?		
How often do you drink alcohol? ○ rarely ○ 1 X/month ○ 1 X/week ○ more than 5X/week		
What do you drink? How many cups of coffee a day?		

DRUGS	Yes	No
Do you use recreational drugs?		
What do you use?		
How often? ○ rarely ○ monthly ○ weekly ○ daily		

EXERCISE	Yes	No
Do you exercise regularly?		
What type of exercise?		
How Often ?		

SAFETY	Do you wear seat belts? ○ never ○ rarely ○ sometimes ○ most times ○ always
RELATIONSHIPS	What is your sexual preference? ○ men only ○ women only ○ both
	Number of sexual partners in the last year? ○ 0 - 1 ○ 2 - 5 ○ more than 5

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